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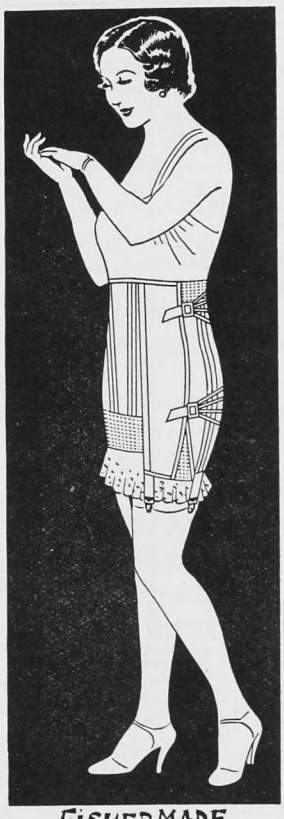

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Clinical Section

Compensable Hernia

By

A. J. FRASER, M.D. (Man.)

Chief Medical Health Officer, Workmen's Compensation Board, Winnipeg, Man.

CLASS 1.

Hernia resulting from external injury or violence inflicted on the abdominal wall and causing puncturing or tearing of the belly wall.

An open wound need not necessarily exist, but evidence of structural injury such as marked localized pain, ecchymosis, etc., with immediate partial or complete disability should be required.

CLASS 2.

Hernia appearing during the course of employment with minimal symptoms of discomfort and with no history of any occurrence having the features of an accident, other than the ordinary efforts of employment.

A hernia of this class is always pre-existent and advancing. Sooner or later it appears as a protrusion or swelling, as the final stage of its development. If the final descent occurs during the course of ordinary employment it cannot be properly held or maintained that personal injury by accident has been suffered, arising out of and in the course of the employment.

Certain symptoms usually go with the descent of a hernia of this type. Complaint is made of "something slipping", of a sense of weakness in the parts on lifting efforts, of momentary sensations of pain, like "pins and needles". Frequently there may be feelings of nausea. Actual vomiting may occur. There is usually no tenderness on palpation.

Cases of this type of hernia are seen in young men around twenty years of age often appearing shortly after they settle into the grind of active heavy work. A congenital origin may safely be assumed.

A larger number of the cases of this type of hernia are observed in men who have passed the forty-five year mark. The muscular structures are becoming atrophic and have lost the tone and resilience of earlier life, with consequent relaxation and the descent of hernial protrusions.

CLASS 3.

Hernia whose appearance is associated with or immediately follows an occurrence of unexpected effort or strain of adequate degree to produce definite and immediate symptoms of personal injury or disability.

This class of hernia is commonly described as the hernia of effort. The usual cause which brings it to the attention of the patient is some sudden strenuous effort, a fall, tripping or stumbling under a heavy load, some sudden jerk, over-reaching in a strained position or some similar occurrence of effort in excess of the ordinary exertions required in the employment.

One single undue effort or strain cannot *de novo* produce a hernia. The statement can be deliberately made that in all cases of inguinal hernia, in this class, the hernia was pre-existent in a partially or incompletely descended state, and the undue accidental strain or effort acts only as an aggravating factor. A further thrust or descent of the hernia is accomplished thereby thus causing the clinical signs and symptoms noted at once by the patient.

Pain in the affected region is noticed at once. It may be severe or moderate in character. It is something much more marked than the "slipping" or "pins and needles" sensations found among the subjects of class two. A sudden perspiration, or a wave of giddiness is noticed. Nausea is common. An attack of vomiting may follow. Complete disability may be immediate. If work is continued it is done with continuing and usually increasing discomfort. The subject is aware that he has suffered some personal injury and it should be required that he mention the matter to others as soon as possible. Usually, the hernial swelling is noted within a few hours, but may not always be clinically observable. When first examined, if within seventy-two hours of its descent, the hernial swelling and the ring are as a rule definitely tender on palpation.

True traumatic hernia in the sense that personal injury is the sole cause of the condition is rare. Only in the cases falling within Class 1 where actual tearing or laceration of the abdominal wall occurs, can the injury be said to be the sole cause. Such cases leave no room for argument as to whether or not compensation should be awarded.

Class 2 comprises a group of cases of hernia without any claim for compensation as the element of accidental causation is entirely absent.

In Class 3 a large number of cases of hernia are found where some occurrence with the features of accident arising out of, and in the course of, employment is a causative factor by aggravating or accelerating the descent of a pre-existent partially descended hernia. In this sense the undue strain or excess effort has caused personal injury with resulting disability, partial or complete.

Certain criteria are proposed to aid in distinguishing the compensable claim from those with no basis of personal injury by accident. Six requirements are suggested. Of these the first point should be required in all claims for traumatic hernia. In addition, three out of the remaining five points should be required in all cases in order to establish a compensable claim based on hernia.

1. Trauma or undue strain or excess effort must be adequate in degree or character to render personal injury probable.

2. Marked pain or discomfort in region of the hernia must immediately follow and be of con-

tinuing duration, until relieved by the fitting of a truss or by operative treatment.

3. One or more of other associated early symptoms must be present, e.g., prostration, transient giddiness, nausea, sudden perspiration.

4. An early descent of the hernia following the alleged injury.

5. Symptoms of such severity that the subject makes complaint of his condition within twenty-four hours, or as soon as possible.

6. No previously known or demonstrable hernia at the present site.

Footnote:—
This article is not to be taken as setting forth the official viewpoint of the Workmen's Compensation Board regarding the requirements to be met in establishing claims based on hernia. The views expressed are considered to be sound and in accordance with the opinions on the subject of the best surgical authorities.—A. J. F.

Testicular Pain Following Repair of Inguinal Herniae

By

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In the operation of inguinal herniotomy greatest emphasis has usually been placed on the repair of the inguinal canal. Undoubtedly, the prevention of a recurrence is uppermost in the surgeon's mind, and a firm solid barrier to prevent subsequent herniation of the peritoneum is planned. In a large majority of cases the operation is a complete success, but occasionally a patient presents himself with pain, discomfort, or swelling, which is more disabling than the original rupture.

The usual late sequlae of an inguinal herniotomy are as follows:—

1. Recurrence of the hernia.
2. Hydrocele of the tunica vaginalis.
3. Atrophy of the testicle.
4. Post-operative neuralgia involving the ilio inguinal and ilio hypogastric nerves.
5. Partial stricture of the vas deferens.

From the viewpoint of the urologist there are two types of post herniotomy testicular pain that are of particular interest: (1) Pain originating in the testicle and associated with definite changes in that organ, and (2) Pain originating in the operative scar and referred to the testicle. In the second type of pain—so-called testicular neuralgia—the diagnosis is established by finding points of exquisite pain and tenderness in the region of the operative scar, which can be relieved by the injection of novocaine solution. In some of these cases there is definite hyperasthesia of the scrotum, but no testicular changes.

It is the purpose of this communication to deal only with one cause of chronic testicular pain, *i.e.*, partial stricture of the vas deferens, to discuss the predisposing factors, its prevention, and the methods of cure.

There are five predisposing factors in the production of partial stricture of the vas deferens:—

1. Chronic vasitis following a gonorrhoeal epididymitis.
2. Injury to the vas over the sharp edge of a retractor when great force is used.
3. Repeated torsion when the vas is rolled over a retractor, *i.e.*, when the finger or dry gauze is used for retraction.
4. Incorporation of the cord in scar tissue in the inguinal canal, or compression in a tight external inguinal ring.
5. Dragging on the traumatized cord by the unsupported testicle.

Apart from a high and complete obliteration of the peritoneal sac and the reconstruction of the inguinal canal without tension, the third keynote in the operative treatment of inguinal herniae, should be the gentle handling of the structures of the cord. While the vas is capable of recovering from minor injuries following ordinary retraction, still, I believe, that one cannot over-emphasize the necessity of handling the cord with the utmost gentleness at all times.

The commoner sites for stricture to occur following herniotomy are at the internal and external inguinal rings. In the former site it is due to an incomplete separation of the vas from the neck of the sac and compression or acute angulation is produced when the sac is closed. In the second site it is due to compression from scar tissue in a tight external inguinal ring.

If the stricture is such that it completely occludes the lumen of the vas, the testicle after first becoming slightly enlarged later becomes much reduced in size, due to degeneration of the parenchymatous tissue. If, however, the obstruction is incomplete but sufficient materially to impede the passage of the external secretion of the testicle, intermittent enlargement of the testicle with chronic testicular pain will result.

The treatment of partial structure of the vas is surgical and consists of (1) Restoring the lumen of the vas to its normal size, or, (2) Converting the partial obstruction into a complete one by vasectomy. If it is desirable to maintain the patency of the vas, an attempt should be made to do a resection with end-to-end anastomosis. The success of this operation has never been definitely proven, and is looked upon with scepticism by some urologists. It is a procedure which should be attempted when the patient is a young man. When operating on an older man, and particularly one who has a family, the second procedure is the operation of choice, *i.e.*, converting the partial stricture into a complete one by vasectomy.

By the operation of vasectomy the obstruction is made complete and the relief of symptoms is

spectacular, being experienced within twelve hours. The anatomical and physiological results in the testicle following complete and incomplete obstruction and the vas are similar to the effects produced on a kidney following complete and incomplete obstruction of the ureter. In complete obstruction of the ureter there is first anuria followed by disuse atrophy of the kidney and in the incomplete obstruction there is dilatation of the collecting portion and enlargement of the kidney. By producing a complete obstruction of the vas there is a cessation of the production of the external secretion of the testicle, atrophic changes in the seminiferous tubules, and a lowering of the internal pressure of the testicle, with a resultant relief of pain.

A case of post-operative stricture of the vas deferens has recently been studied and treated. A laborer, age 57, reported in September, 1934, complaining of testicular pain, which had followed a left inguinal herniotomy done in 1930. A Bassini operation had been performed and no recurrence had taken place. He stated that his pain began shortly after his discharge from the hospital and was not relieved by the use of a scrotal suspensory. Within four months after the operation he had developed a hydrocele of the left tunica vaginalis. This had been aspired without relieving the testicular pain. In 1931 the sac of the hydrocele was excised and at this operation it was noted that the testicle was large and the consistency less firm and more spongy than normal. He continued to have chronic testicular pain with nightly exacerbations and these exacerbations were associated with an increase in the size of the testicle. The exacerbations of pain and the swelling could always be produced by sexual excitement, or by external heat applied to the scrotum.

Scrotal supports and the injection of the ilio-inguinal nerve did not relieve the symptoms. During the day the testicle always decreased in size, but it remained abnormally sensitive. General examination and special examinations of the prostate and seminal vesicles were negative. A diagnosis of partial obstruction of the vas deferens was made.

At operation, in October, 1934, under local anaesthesia the vas was exposed from the level of the globus major of the epididymis to the external inguinal ring, through a small upper scrotal incision. No definite point of constriction could be demonstrated externally and the cord was divided about the middle. A fine canulae probe was inserted in the lower segment and the injection of a small amount of solution met with the normal amount of resistance. An attempt to inject the upper segment of the vas, however, met with firm resistance just at the external inguinal ring, and it was impossible to force the solution along the duct. Slight dilatation of the duct was noted during the injection of this segment. A vasectomy was done by tying off and carbolizing the divided ends of the duct. The next morning the patient stated he had not had his usual nocturnal testicular pain and had not noted any swelling of the testicle that night. He has remained free of these symptoms now for the first time since his herniotomy five years ago. Previously his discomfort had prevented him from carrying on with his usual employment and the loss of sleep and constant worry over his condition had produced a marked neurosis. He has now returned to his former employment, his sleep is undisturbed, and his marital relations are not followed by severe testicular pain as formerly. The testicle gradually reduced in size and is now slightly smaller than the normal right testicle.

A Point in Medical History

The following note appeared in the *Free Press* of March 18th, 1935:

> "Sixty Years Ago — March 18th, 1875
>
> "The operation of lithotomy was successfully performed on a Winnipeg citizen, James Sinclair, by Dr. O'Donnell, assisted by Drs. Bird, Codd and Baldwin; a stone was removed weighing 1¾ ounces."

On the following day a note came to one of the editors of the *Review*, as follows:

> "You doubtless saw this clipping in this morning's Free Press. I was intrigued (sic) because I have told so often that I performed the first successful laparotomy in 1886 that I have come to believe it.
>
> "Lithotomy in 1875 would be from the bladder and therefore a laparotomy, or would Dr. O'Donnell use the perineal route? I have given away my surgical works and cannot verify dates. Have I been lying all my life?
>
> "Fraternally yours,
>
> H. H. CHOWN."

Possibly some of the readers of the *Review* can throw light on this question. Was Dr. O'Donnell's operation performed in 1875 a suprapublic or a prineal lithotomy? We understand that the operation performed in 1886 in the Winnipeg General Hospital by Dr. Chown was an ovariotomy. Will our readers please give us the benefit of their knowledge?

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*Practical Points in the Use of the New Death Certificate

By

R. D. DEFRIES AND A. H. SELLERS

School of Hygiene, University of Toronto

The ambiguity of the questions relating to cause of death has been responsible for considerable confusion and dissatisfaction with the old medical certificate and practising physicians as well as medical statisticians have for some time felt that a revision of the standard Canadian death certificate was necessary and a fundamental step toward improvement in accuracy of medical records. It is therefore of interest that a new Canadian certificate is now being distributed for national use by the Dominion Bureau of Statistics. The questions relating to cause of death on this certificate are essentially those on the present English form, and they embody the principles suggested by the Health Committee of the League of Nations in 1925. This new form includes all the considerations which experience has shown to be necessary in death certification.

I	CAUSE OF DEATH	*Example 1*
Immediate cause Give disease, injury or complication which caused death, **not** the mode of dying, such as heart failure, asphyxia, asthenia, etc.	(a) Acute diffuse peritonitis. due to	
Morbid conditions, if any, giving rise to immediate cause (stated in order proceeding backwards from immediate cause).	(b) Carcinoma of transverse colon. due to (c).....	
II		
Other morbid conditions (if important) contributing to death but **not causally related to immediate cause**	....	

Important Changes

The outstanding change in the new medical certificate of death is in the form of the questions relating to the cause of death. The morbid conditions relating to death are divided on the certificate into two sections. In section I are those related to the "immediate cause" of death, and in section II those not causally related thereto.

I	CAUSE OF DEATH	*Example 2*
Immediate cause Give disease, injury or complication which caused death, **not** the mode of dying, such as heart failure, asphyxia, asthenia, etc.	(a) Bronchopneumonia. due to	
Morbid conditions, if any, giving rise to immediate cause (stated in order proceeding backwards from immediate cause).	(b) Operation. due to (c) Strangulated inguinal hernia.	
II		
Other morbid conditions (if important) contributing to death but **not causally related to immediate cause**	Chronic nephritis.	

In a large number of cases only one cause will need to be stated. Where this is the case the physician makes such statement under heading I on the first line (*a*). When, however, two or more are entered, the confusion which formerly arose between "cause of death" and "contributory or secondary cause", is avoided by the logical arrangement of the facts. Those other morbid conditions (if any) of which the immediate cause entered on (*a*), was the consequence are recorded on lines (*b*) and (*c*) of section I in order of causal relationship, stating the most recent one first and then others in order. Those "other important contributory morbid conditions" which are NOT causally related to the immediate cause (*a*) are to be entered under section II. Entries under this section should be reserved particularly for those cases in which death was due to a combination of maladies, none of which would have been fatal alone. In such cases, the physician's judgment alone can afford guidance to the tabulator. It is emphasized that only those morbid conditions which the physician considers actually important contributory factors, should be recorded.

The following examples illustrate the use of the new certificate and its value in presenting clearly the physician's opinion.

Example 1

A patient in whom a diagnosis of carcinoma of large bowel had been made, was operated upon and a resection done. Erosion having occurred prior to operation, acute diffuse peritonitis developed and the patient died two weeks after operation.

As there were no "other important contributory morbid conditions" in this case, no statement under II is needed, and the certificate should read as shown.

Example 2

When two or more independent morbid conditions are present, the ambiguity of the old form led to much confusion because of the varying interpretation of "cause of death" and "contributory cause" on the old form. For example, if a patient has both diabetes and tuberculosis, only the physician can decide which of these two should be recorded as cause of the death. The new certificate offers a solution of this problem by placing entirely on the physician the choice of the cause which he feels deserves tabulation as cause of death in the records. The following example illustrates these points.

A patient who had chronic nephritis developed a strangulated inguinal hernia and was operated on. Subsequent to operation, he developed bronchopneumonia and died.

Presuming that the physician felt that the chronic nephritis was an **important** contributory

* For the Committee on the Certification of Causes of Death, Section of Vital Statistics, Canadian Public Health Assn.

factor in this case and the strangulated hernia of first importance, the medical certificate of cause of death would appear as follows:

The significance of "due to" is largely one of time relationship, implying causation in this broad sense.

Every physician appreciates the importance of accurate mortality records, and **the statistics can never be more accurate than the statements which he makes.** If the physician clearly understands the simple principles on which the questions relating to cause of death on the new form are based, he will not only find certification of deaths simpler and more satisfactory, but he will find that it gives him the opportunity, not heretofore possible, of expressing clearly his opinion as to the cause of the death of his patient. The new medical certificate of death should provide a more accurate expression of the opinions of the medical practitioner respecting causes of death.

Medical Library University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. Holland, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

"The Canadian Medical Association Journal" —April, 1935.

"An Attempt to Inhibit the Development of Tar-Carcinoma in Mice" (Second Report) — by J. R. Davidson, M.D., Winnipeg.

—Dr. Davidson shows by excellent photographs the effect of his special diet on mice subjected to tar. All were free from carcinoma while the tarred mice fed on an ordinary diet, all died and all had carcinomatous growths at autopsy.

"Malignant Conditions of the Skin and their Treatment by Radiation"—by R. K. Patterson, Ottawa.

"Gonococcal Taenosynovitis of the Hand" — by D. W. G. Murray and J. R. E. Morgan, Toronto.

—A case report—the condition occurring six days after the first appearance of an acute gonorrheal urethritis.

"Cancer of the Breast"—by Max Cutler, M.D., Chicago.

—A paper read at the Annual Meeting of the Canadian Medical Association, Calgary, 1934.

"Total Ablation of the Thyroid Gland in the Treatment of Angina Pectoris and Congestive Heart Failure"—by John Hepburn, M.B., Toronto.

—A small series of cases is reported, and a very short period of time has elapsed since operation. Considerable relief has been effected in two anginal cases, but no definite improvement in cases of heart failure.

"The Diagnosis and Treatment of Intestinal Amoebiasis" — by James C. Paterson, M.D., Sarnia.

"The Practitioner"—April, 1935.

This issue is composed of the following series of articles on "Diseases of Children."

"Tiredness as a Symptom in Childhood" — by G. F. Still, M.D., LL.D., F.R.C.P.

"Constitution and Diathesis in Childhood" — by C. Paget Lapage, M.D., F.R.C.P., Manchester.

"Diseases of the Newly-Born" — by Norman B. Capon, M.D., F.R.C.P., Liverpool.

"The Artificial Feeding of Infants"—by Wilfred Sheldon, M.D., F.R.C.P., London.

"The Diet of the Pre-School Child" — by Eric Pritchard, M.A., M.D., F.R.C.P., London.

"Dehydration and Acidosis in Gastro-Enteritis" —by Stanley Graham, M.D., F.R.C.P.S., Glasgow.

"The Diagnosis and Treatment of Acute Rheumatism"—by F. J. Poynton, M.D., F.R.C.P., Great Ormond Street.

"The Diagnosis of Heart Disease in Children"—by Reginald Miller, M.D., F.R.C.P., London.

"Chronic (Non-Tuberculous) Lung Disease in Childhood"—by A. G. Maitland-Jones, O.B.E., M.C., M.D., F.R.C.P., London Hospital.

"Pituitary Disorders in Childhood"—by H. Gardiner-Hill, M.A., M.D., F.R.C.P., St. Thomas's Hospital.

"Skin Diseases in Children"—by R. T. Brain, M.D., M.R.C.P., Great Ormond Street.

"Intestinal Parasites"—by F. M. B. Allen, M.D., M.R.C.P., Belfast.

"Minimal Infections"—by Norman Hallows, M.D., M.R.C.P., D.P.H.

"Appendicitis in Children" — by A. Simpson-Smith, M.A., M.Ch., F.R.C.S., Surgeon, The Hospital for Sick Children, Great Ormond St.

"Talipes Equino-Varus"—by Denis Browne, M.B., F.R.C.S.

"Some Diseases of the Eye Common in Children" —by G. G. Penman, M.B., F.R.C.S.

"Laboratory Aids to Diagnosis" — by Norah Schuster, M.B., Ch.B., Pathologist, Royal Chest Hospital.

"The Journal of Bone and Joint Surgery" —April, 1935.

"Stimulation of Healing in Non-Healing Wounds by Allantoin occurring in Maggot Secretions and of Wide Biological Distribution" — by William Robinson, Ph.D., Washington, D.C.

—A preliminary report of investigations to determine the reason for healing in maggot treatment of wounds. Allantoin a constituent of urinary secretions and the break-down product of uric acid has shown beneficial results in non-healing wounds.

"Fractures of the Forearm." An Analysis of 415 Cases with Special Reference to Disabilities —by Barney J. Hein, M.D., F.A.C.S., Toledo, Ohio.

—A long article, well illustrated by drawings.

[Continued on Page 17]

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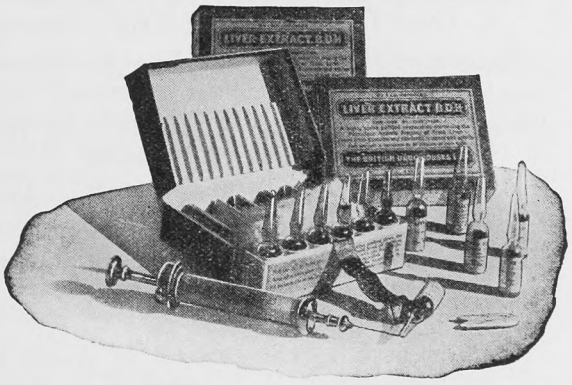
(For Intramuscular Injection)



For the treatment of pernicious anaemia the parenteral administration of an extract of liver possesses many advantages over other forms of therapy in that it produces a rapid and enhanced response; moreover it is relatively cheap. As stated in a recent article (Practitioner, March 1935, p.272) it is important to use only those extracts which have been tested clinically and have proved to be haemopoietically active; the administration of a relatively inactive preparation of liver to a patient who is seriously ill fails to bring about the desired result at the critical period, whilst, alternatively, the response to the parenteral administration of a potent extract of liver is described as 'extremely dramatic'.

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Editorial and Special Articles

The Manitoba Medical Association Review

Formerly the Bulletin of the Manitoba Medical Association

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Editorial

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The Organization of the Medical Profession in Canada

The May number of the *Canadian Medical Association Journal* has an editorial entitled "The Need for Unity in the Canadian Medical Association." After discussing the necessity for some modification of the present organization of medicine in Canada, it is stated that the Executive of the Manitoba Medical Association "In a unanimously supported resolution stated that they were prepared to abandon the designation of 'Manitoba Medical Association' and become 'Canadian Medical Association–Manitoba Branch,' provided that the other provinces did likewise. This is the message that Doctors McEachern and Routley have carried all over Canada." Further, it is stated "The trip of the President and Secretary, bearing their message over Canada, seems to have taken on the character of a triumphal march." Further on it is stated "The time is not yet ripe for any concrete proposals to be laid down. The matter has been under advisement by the Executive Committee of the National Association, and so soon as the new Constitution and By-Laws are adopted it will be possible to make some advance."

After reading carefully the memorandum which was sent by the Executive of the Manitoba Medical Association to the Executive of the Canadian Medical Association in October, 1934, it is difficult to understand how the features of this memorandum referred to by the writer of the editorial could have been given so much prominence. The proposals put forward by the Executive of the Manitoba Medical Association involved a radical change in the organization of the medical profession throughout Canada. The mere change of the names of the provincial associations was an incidental detail.

The need for an effective and representative organization of Canadian medical men is urgent at the present time. Many impractical schemes for so-called 'state medicine' and alleged 'health insurance' are being put forward by various people outside of the profession. For this reason it is essential that the Canadian Medical profession should be able to speak through a representative body.

The memorandum from the Manitoba Medical Association was printed in the November, 1934, number and reprinted in the April, 1935, number of the *Review*.

The Reports from the Committee on Sociology

There are published this month two reports from the Committee on Sociology of the Manitoba Medical Association. One deals with the circular with regard to Relief Rations, and it is interesting to note that the response to this questionnaire was quite satisfactory. The other report deals with one year's experience of the Winnipeg Plan for medical services for citizens in receipt of relief funds. This is a very important memorandum in that it constitutes the first record of any comprehensive medical service in any part of Canada. It is not suggested that it is sufficient to form a basis for any plan for a general medical service, but it indicates very definitely the need for securing preliminary figures of the cost of medical care before any proposals for any form of compulsory health insurance are considered if there is to be any reasonable prospect of avoiding such a scheme being wrecked as the result of miscalculation of probable costs. The Committee on Sociology is to be congratulated not only on this report but on the enormous amount of detailed work involved in seeing that the Winnipeg Plan is working efficiently, and smoothly. —C. W. MACC.

Minutes of Executive Meeting

Minutes of a meeting of the Winnipeg members of the Executive of the Manitoba Medical Association, held in the club-rooms of the Medical Arts Building on Friday, May 17th, 1935, at 12.30 noon.

Present.

Dr. Harvey Smith
Dr. F. G. McGuinness
Dr. J. S. McInnes
Dr. F. A. Benner
Dr. W. E. R. Coad
Dr. R. R. Swan
Dr. F. D. McKenty
Dr. J. C. McMillan
Dr. F. W. Jackson

Dr. Smith read a very excellent report on the last Executive meeting of the Canadian Medical Association, and it was moved by Dr. J. S. McInnes, seconded by Dr. F. G. McGuinness: That the Executive express to Dr. Smith their deep appreciation for his trouble in preparing and submitting a report, and recommend that it be printed in the *Review*. (See below). —Carried.

Arising out of the report a discussion took place as to who might be suggested as Manitoba's representative next year on the Executive Committee of the Council. It being understood, of course, we actually have no right to make any nomination, but it was felt that the Council of the Canadian Medical Association would be only too glad to consider any recommendation we might make.

In view of the present trend in medical practice, it was moved by Dr. Harvey Smith, seconded by Dr. R. R. Swan: That Dr. E. S. Moorhead be approached and be asked to allow us to put his name forward as a Member of the Canadian Medical Association Executive. —Carried.

The Secretary then brought up the question of the advisability of the President being present at the Council Meeting of the Canadian Medical Association in Atlantic City in June. Dr. McMillan suggested that the Secretary should also be present, and it was moved by Dr. J. C. McMillan, seconded by Dr. F. A. Benner: That the President be allowed fifty dollars ($50.00) towards expenses of the Council Meeting in Atlantic City, and that the Secretary should be allowed fifty dollars ($50.00), providing he does not get his expenses paid by the Canadian Medical Association as representing Dr. Harvey Smith on the Executive Committee.

Dr. Swan brought up the question of the Annual Meeting of the Association in September, and, after considerable discussion, it was moved by Dr. R. R. Swan, seconded by Dr. J. S. McInnes: That one full evening, preferably September 11th, be set aside as the business meeting of the Association. —Carried.

There being no further business to come before the meeting, the meeting then adjourned.

May 17th, 1935.

To the President and Members
of the Executive Committee
of the Manitoba Medical Association.

Gentlemen:

I beg to report on the transactions of the Executive Committee of the Canadian Medical Association held in Toronto on April 6th last, and a few other matters in which the members of this body may be interested.

1. Arrangements were completed for the joint meeting of the American and the Canadian Medical Associations at Atlantic City from the 10th to the 14th of June next, preceded, starting on the 9th, by meetings of the Executive Committee and Council.

2. The widow of the late Dr. F. N. G. Starr has given a medal in memory of her husband, to be awarded periodically for achievement by a Canadian doctor in any field.

3. 3,000 copies of the Report of the Economic Committee have been printed in French, and will be distributed to French-Canadian physicians. This represents the beginning of a movement designed to link up more closely French and English speaking practitioners throughout the Dominion, and to develop between them a better understanding of each other's problems.

4. Dr. Grant Fleming, at the request of the British Columbia authorities, spent several weeks in that province, assisting in drafting the medical legislation relating to Health Insurance which it is proposed introducing in the British Columbia Legislature. That an official of the Canadian Medical Association should have been asked to assist in the preparation of such legislation, is a source of gratification to those who hope our Federal organization may be of increasing value in the solution of provincial problems, and especially of those in which it is desirable that uniform principles and policies should be established.

5. The actuarial basis upon which a system of Health Insurance might be established in any of the Provinces of Canada, will be discussed by representatives of the Canadian Life Insurance Officers' Association, and the Canadian Medical Association. It is recognized that no system can hope to succeed, which is not founded upon sound actuarial knowledge and practice.

6. The Annual Meeting of the British Medical Association will be held in Melbourne next September. It is not anticipated that there will be a large attendance from Canada.

7. Revision of the Constitution and By-Laws proved a formidable task. The Committee on revision gave respectful consideration to the memorandum submitted by our Executive last October. The proposal made in Winnipeg at the last meeting of the Manitoba Medical Association, that a federation of all Provincial associations in the Canadian Medical Association should be brought about, has had a most sympathetic reception in the majority of the Canadian provinces. In only one, however, has the principle been officially accepted. The matter is one involving many considerations relating to membership and finance that must be ironed out before the scheme can be generally accepted. The proposal which I sponsored, that representatives of the various provinces should attend the annual meeting of Council, instructed regarding whom they should support for membership on the Executive, was not

supported on the theoretical ground that non-members of the Association might under such a plan have a say in the selection of representatives. Personally, I think little of this argument, and would recommend that at the meeting of this Executive, held immediately prior to the Annual Meeting of the Canadian Medical Association, our delegates be instructed to submit their recommendations on the floor of Council for the guidance of the Nominating Committee.

8. A report on the control of specialists in Canada will be submitted at the meeting of Council at Atlantic City, which if approved and put into operation in the various provinces, should do much towards lessening the evils connected with the pseudo-specialization that prevails so widely throughout the Dominion.

9. A Study Committee on Cancer has been established under the auspices of the Canadian Medical Association, whose main objectives are: the propagation of knowledge concerning cancer, and the provision of funds for study and research in connection with this disease. On account of the Silver Jubilee Cancer Fund appeal under the auspices of the Governor-General, the activities of the Canadian Medical Association Committee may be held in abeyance pending the result of information regarding the success of the Jubilee campaign for funds.

10. In response to the request from Manitoba that the Canadian Medical Institute should permit policy-holders to be examined by their own physicians, I was instructed to explain that the Institute does approve of such examinations being made.

11. The Executive Committee by resolution expressed its appreciation of the action of the Manitoba Medical Association in supplying copies of the minutes of our Executive meetings, which proved most valuable in keeping the General Secretary in touch with activities in this province.

12. The Annual Report of the Executive Committee refers to the Ottawa conference held on the 25th and 26th of last April, in which were assembled the Ministers of Health from all the provinces of the Dominion, at which the following resolutions were passed:

1. That a Royal Commission be appointed to examine into the whole question of health activities and medical service in the Dominion of Canada.
2. That the Ministers of Health for Canada, under the Chairmanship of the Minister of Pensions and National Health of the Dominion Government be constituted as a Cabinet of Health to be called to meet periodically at the pleasure of the Honourable Minister of Health for Canada.
3. That there be established as an adjunct to this Cabinet of Health, an Advisory Committee of representatives from the various bodies qualified to be of assistance to such a Cabinet.
4. That Departments of Health, both national and provincial, constantly endeavor to engage in closer co-operation with the Medical Associations of Canada, with a view to promote health interests in Canada.
5. That the Conference approve of grants-in-aid to voluntary health agencies, but that such agencies should confer together and present jointly their obligations to Governments for money-in-aid, such grants later to be made upon the basis of the total amount of funds available compared to the total amount of the budget approved by the conference of voluntary agencies.

A reading of the foregoing justifies the belief that this conference has been barren of results, and has resorted to the well known political expedient, of referring the issues with which it was called upon to deal, to that home of the friendless, a committee. I trust that future events may prove that this estimate of the situation is incorrect.

Time does not permit of a more extended reference to many other matters with which, as your representative, I have been called upon to deal.

In conclusion, let me say that it has been a great pleasure and a privilege to have represented Manitoba on the Canadian Medical Association Executive during the past year.

I find it impossible to attend the forthcoming meeting, and wish therefore to place my resignation in your hands. My view is that our representative should be someone who is in active contact with current medical problems, possesses the confidence of the profession in Manitoba, and will be able to speak with authority and good judgment on the various subjects with which the Executive is called upon to deal.

I would suggest that in conformity with the idea I have already expressed, our delegates should be instructed to ask for the appointment of whomsoever this Executive considers may best represent them on the Executive of the Canadian Medical Association; thus our link with that body will be vital and there will be little chance of our ties of sentiment or of interest becoming enfeebled or attenuated.

As my resignation to-day means the severance of my last official connection with organized medicine, with whose interests I have been associated for forty years, let me say how much I appreciate the backing which you all have given me in the performance of my official duties, and express the opinion that the future of the Canadian Medical Association was never more promising that it is to-day, but that if it is to carry on its great functions on behalf of practitioners of medicine in the Dominion properly, it should include in its membership all medical men who are alive to the needs of their profession.

(*Signed*) W. HARVEY SMITH.

Report from the Committee on Sociology of the Manitoba Medical Association

One Year of Winnipeg Plan for Medical Services for Citizens on Relief

In view of the interest throughout the Dominion on the question of Federal or Provincial Health Insurance the subjoined record of the operations of the Winnipeg Relief Plan for a period of one year will probably prove to be of extreme value.

When the Winnipeg plan was adopted, the only figures available led us to express the view that a relief medical service could be provided on a modified scale of fees for $1.75 per head per annum. The marked discrepancy between theory and fact suggests the scale of fees submitted in the various Provincial Health Insurance plans may also be very wide of the mark, and the profession must be warned about entering on a course which will prove to be detrimental in its present form to their interests.

This report is submitted in the hope that every doctor who is interested will study and analyse it before endorsing or even accepting terms about which he knows little. It is believed that it is the only report of its kind available in the Dominion, and possibly in the North American Continent. The figures for an additional ten thousand relief cases in the suburbs of Winnipeg do not materially alter the picture.

SUMMARY OF MEDICAL CHARGES FOR SERVICES TO PATIENTS ON RELIEF
from March 1st, 1934, to February 28th, 1935 (12 months)

			Percentage		Average Month Over a 12 Month Period
Calls:					
House	15,987	$ 23,992.75		1,332	$1,999.40
Office	22,265	22,448.25		1,855	1,870.69
Hospital	8,065	5,185.70	50	672	432.14
Operations:					
Major	519	20,533.00		43	1,711.08
Minor	900	7,580.73		75	631.73
T. & A.	727	10,852.50		61	904.38
Fractures	33	671.66	37	3	55.97
Maternity:					
Hospital	702	6,994.75		59	582.90
House	137	2,600.00	9	11	216.67
Sundries:					
Special Exams.	243	1,198.50		20	99.88
X-rays	193	1,677.33		16	139.77
Anæsthetics	234	825.58		20	68.80
Dental	1	1.25		—	.10
Cousultations	266	792.00	4	22	66.00
GROSS TOTAL		104,647.00			8,720.58
NET TOTAL		93,890.89			7,824.24
NUMBER DOCTORS RENDERED ACCOUNTS		2,590			216
NET AVERAGE COST PER DOCTOR					36.25
CASES REPORTED HOSPITALIZED		2,029			169

AVERAGE NUMBER OF PEOPLE ON RELIEF PER MONTH 34,040

AVERAGE GROSS COST PER PERSON FOR 12 MONTHS $3.07

AVERAGE NET COST PER PERSON FOR 12 MONTHS $2.76

After reading the above figures there are many points to be considered. The percentages show what a large proportion of treatment is provided by the general practitioner, which is interesting in view of the fact that the patient is entitled to choose his doctor.

The scale of fees is as follows:

All major surgery which includes a reasonable amount of post-operative care, $25.00. Tonsillectomy, $15.00. Confinements in Hospital, $10.00 —in home, $20.00—both to include ante and post natal care in a normal case. House calls, $1.50. Office calls, $1.00. Eye, Ear, Nose and Throat specialists get a somewhat higher fee for office consultations, but a certain list of minor operations and treatments may have to be performed at this consultation. Hospital visits are fifty cents (50c)—but only one visit every second day is paid for, unless the patient is shown to be suffering from an acute and serious ailment. Con-

sultations are $3.00, and X-ray work is done on an agreed schedule.

It is not claimed that these fees are remunerative. There are several factors which reduce the cost to the City. Two whole time and two part time doctors, employees of the City, treat relief cases; the salaries of these medical officers are not included in the summary. The difference between the gross and net totals is due to the fact that, with few exceptions, no doctor is paid more than $100.00 in one month, though his earnings may be considerably above this figure. The City undertakes all administration.

Before the gross total is reached, all bills submitted are taxed. Visits to note progress, or for minor treatments, either of which could have been done by a visiting nurse, are refused. If the number of visits appears to be excessive, the medical referee, a City official, reduces them, and the practitioner may submit his case for redress to a Medical Board.

All emergencies can be treated without written authority from the Medical Referee. Chronic cases requiring surgical or prolonged and sometimes expensive medical treatment are frequently referred to the Medical Advisory Board for an opinion as to necessity for treatment or likelihood of benefit. For reasons of economy, tonsillectomies in adults and refractions are rarely authorized.

It will be seen that all these restrictions are intended to reduce the cost of supplying medical service to the unemployed on relief. The service is complete insofar as relief of pain, protection of life and prevention of disability or death are concerned; but the reader must ask himself, would people under a Health Insurance scheme be satisfied with such a modified service?

An efficient but restricted service should have cost the City of Winnipeg $3.07 per head per annum. If the patient under a Health Insurance plan accepted all the treatments recommended by his doctor, and insisted on the employment of the modern aids to diagnosis and treatments, it seems certain that the cost would be very much higher than the estimates frequently put forward, that is, if the doctor is to receive a reasonable remuneration.

Report from the Committee on Sociology of the Manitoba Medical Association

Summary of Replies re. Relief Rations

The Committee on Sociology of the Manitoba Medical Association are desirous of an expression of opinion from the medical men as to the sufficiency of relief rations supplied to the unemployed. It is not intended that you should carry out an investigation, but answer the following questions, based on your experience of the past year.

139 Replies received out of 315 sent out.
67 Replies negative to everything.

1. (*a*) Do many of your relief patients *voluntarily* complain of food shortage?
   Negative – 98 Positive – 40
   (*b*) If so, what shortages are alleged?

Milk	Meat	Fruit	Veg.	Groc.	Fish
37	7	6	3	4	1

2. Do they complain to you of lack of means for cooking?
   Negative – 128 Positive – 10
   (Four of which mentioned lack of gas, wood or electricity to cook)
3. Are you seeing increasing numbers of the following deficiency diseases in persons six months or longer on relief:
   (*a*) Rickets?
   Negative – 134 Positive – 2
   (*b*) Indeterminate gastro-intestinal symptoms?
   Negative – 118 Positive – 20
   (*c*) Unexplained diarrhoea?
   Negative – 133 Positive – 5
4. (*a*) Do you find evidence of under-nourishment, and if so, what?
   Negative – 115 Positive – 21
   (*b*) If (*a*) in affirmative, is it due to insufficient food or poor management as regards purchase and cooking?
   See letter.
5. Have you any general opinions to offer?
   See letter.

Evidence.

Underweight in children	4
Underweight in both children and adults	4
Anæmia, poor resistance, ordinary colds, &c.	4
Weakness mostly in mothers	1

The following letter summarizes the report:

A. MacNamara, Esq., May 20th, 1935.
Assistant Deputy Minister,
Department of Public Works,
Legislative Building,
Winnipeg, Man.

Dear Sir,—

As promised, I am sending you a complete report on circular. The response to date has been more satisfactory than one usually gets from such a questionnaire. Out of 315 doctors on the panel, only 216 on the average attend cases in any one month, and some of those see only one or two patients: therefore, I imagine that we have probably obtained information which is not likely to be altered by further returns.

Of the 67 replies which were negative to everything, 19 stated in question five that relief cases were well fed, in many cases better than before, and better than men working on a low wage scale.

Of the 40 positive, in reply to four (*b*), 10 doctors believed the condition to be affected in varying degrees by poor cooking, poor management, or both. Four, even while pointing out shortages,

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considered that the diet was satisfactory. Ten doctors gave insufficient food as the cause, in some cases aggravated by poor management.

Three doctors, in answering four (*a*), state that under-nourishment is no worse among unemployed than employed.

I think the commission will get the same reaction from the figures submitted on attached sheet as I did.

With regard to the shortage of milk, I quote the opinion of a children's specialist: "A few complain of insufficient milk, but usually it is because they think a child requires a quart of milk a day. When I explain to them that twenty-four ounces are sufficient for the average child, their complaints usually cease."

Yours faithfully,

(*Signed*) E. S. MOORHEAD,
Chairman,
Committee on Sociology.

PRESENT STATUS OF MEAD JOHNSON
Vitamin A Research Award

THIS award was originally established by Mead Johnson & Company January 30, 1932. "Mead Johnson & Company announces an award of $15,000 to be given to the investigator or group of investigators producing the most conclusive research on the vitamin A requirements of human beings." (See J.A.M.A., January 30, 1932, pages 14-15).

On February 11, 1933 (J.A.M.A., pages 12-13), "At the suggestion of the Judges, a second (additional) Award of $5,000 is now offered. The basis for this enlargement is in the obvious possibility that within the time limit set (Dec. 31, 1934), no suitable evaluation of the vitamin A requirements of human beings will have appeared. On the other hand, a laboratory investigation may have been published which will point the way toward clinical evaluation."

On that date, the Judges for the award were announced:

Isaac A. Abt, Northwestern University; K. D. Blackfan, Harvard University; Alan Brown, University of Toronto; Horton R. Gasparis, Vanderbilt University; H. F. Helmholz, Mayo Clinic; Alfred F. Hess, Columbia University; E. V. McCollum, Johns Hopkins University; L. B. Mendel, Yale University; L. T. Royster, University of Virginia; and Robert A. Strong, Tulane University.

The Judges met in Detroit, April 10, 1935, and took the following action:

(1) To postpone until December 31, 1936, awarding of the main (Clinical) Award.

(2) To divide the second (Laboratory) Award, one-half to Dr. S. B. Wolbach, Harvard University, for his basic work on the pathology of avitaminosis A and his investigations on the regeneration of epithelial tissue impaired by vitamin A deficiency, and the relationship of vitamin A to the integrity of the teeth; and one-half to Dr. Karl E. Mason, Vanderbilt University, for distinguishing exactly between the pathology of avitaminosis A and avitaminosis E, and for his contribution to the quantitative relationship of vitamin A deficiency to the keratinization of germinal epithelia.

Some of this original work is still in press.

Checks for $2,500 each, in accordance with the decision of the Judges, were promptly mailed by Mead Johnson & Company to Dr. S. B. Wolbach and to Dr. Karl E. Mason.

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DIGBY WHEELER, B.A. (Tor.), M.A., M.D., C.M. (Man.), M.R.C.S. (Eng.), L.R.C.P. (Lond.)

Education Committee

C. W. MACCHARLES, M.D. (Man.)
W. H. SECORD, M.C., M.D., C.M. (McG.)
C. C. EVERSON, M.D., C.M. (Man.)
W. F. STEVENSON, M.D. (Man.)

Finance Committee

W. H. SECORD, M.C., M.D., C.M. (McG.)
W. H. RENNIE, M.D. (Man.)
W. J. HARRINGTON, M.D. (Man.)

Legislative Committee

J. S. POOLE, M.D., C.M. (Man.)
H. O. MCDIARMID, M.D. (Man.)
W. G. CAMPBELL, M.D., C.M. (McG.)
C. W. MACCHARLES, M.D. (Man.)
W. H. SECORD, M.C., M.D., C.M. (McG.)
D. G. ROSS, M.D., C.M. (Man.)

Minutes of Executive Meeting

A meeting of the Executive Committee of the College of Physicians and Surgeons of Manitoba was held Saturday, April 27th, 1935, at 7 o'clock p.m., in the office of the Registrar, 605 Medical Arts Building, Winnipeg.

The members present were: Dr. William Turnbull (chairman), Dr. C. W. Burns, Dr. W. G. Campbell, Dr. H. O. McDiarmid, Dr. W. H. Rennie.

Numerous questions were before the meeting, several of which are not yet for publication.

Re. Alleged Qualification of Dr. P. C. Robertson, The Pas, Manitoba.

A complaint had been received from a doctor in regard to Dr. P. C. Robertson, The Pas, Manitoba, using the qualifications, F.R.C.P., F.R.C.S., England, after his name in advertising material and on his letterhead stationery.

Dr. Campbell wrote to Dr. Robertson on different occasions, asking for an explanation as to the dates when he received such qualifications. Dr. Robertson did not disclose this information. As the first qualification is honorary only, the Registrar considered it advisable to inquire from the Registrar of the General Medical Council of Great Britain when the above was granted to Dr. Robertson.

The Chief Clerk of the General Medical Council, in the absence of the Registrar, forwarded copies of the correspondence relating to this matter, and it is obvious that these qualifications were never bestowed upon Dr. Robertson, and that he was attaching the above letters after his name falsely.

Moved by Dr. Burns, seconded by Dr. McDiarmid: "That the Registrar write to Dr. Robertson with reference to the correspondence between this office and the General Medical Council of Great Britain, regarding his using the letters F.R.C.P., F.R.C.S., England, in his advertisements and stationery, stating that these files were considered by the Executive Committee of the Council of the College of Physicians and Surgeons of Manitoba, on April 27th, 1935, and that we would request a prompt reply with a disclaimer, in regard to the above letters to complete our records, and also to satisfy the General Medical Council of Great Britain." —Carried.

Communication from Dr. ..... re. Dr. ....., Winnipeg, Manitoba.

A letter was received from Dr. ....., in regard to what he considered an unfair and unjust act by Dr. ....., inasmuch as he directed a patient to another doctor for operation, after having been informed by the patient's father to have Dr. ..... perform the operation. Accompanying Dr. .....'s letter was a signed statement from the patient, to the effect that he had requested to have Dr. ..... perform the operation (appendectomy).

Moved by Dr. Burns, seconded by Dr. Rennie:

"That the Registrar be instructed to write Dr. ....., stating that this office has had this complaint. That, apparently, from the letter we received, he took the matter in his own hands, and that the College of Physicians and Surgeons of Manitoba would ask him for an explanation." —Carried.

Communication from Dr. Jackson, Deputy Minister of Health, re. an Irregular Practitioner.

A communication was forwarded from Dr. Jackson, which he had received from Dr. J. D. Adamson, Medical Director, St. Boniface Sanitarium, in reference to a young lady, suffering from tuberculosis enterocolitis, who had been treated by an irregular practitioner, before admission to the hospital.

The name of the irregular was not given, but it has since been ascertained to be Mr. ....., Somerset Building, Winnipeg.

Since receiving this complaint, the young lady had died.

Dr. Campbell asked the Committee what it wished to do.

Moved by Dr. Burns, seconded by Dr. McDiarmid: "That the Registrar write to Dr. Jackson, stating that this is distinctly a case for the Attorney-General's Department, and we would like a written reply from Mr. Major before taking any steps." —Carried.

Report of Prosecutions.

(a) Interim Report re. J. P. Oshanek, Chiropractor, Winnipeg.

Dr. Campbell reported that the case of Oshanek had been before the Court, and the chiropractor had been convicted by the Magistrate and fined twenty-five dollars. Mr. Oshanek's lawyer had stated he would present the case before the Court of Appeal, which will be decided probably at the May session.

(b) Re. Lozo, Chiropractor, Aikins St., Winnipeg.

Dr. Campbell informed the Committee that Lozo, Chiropractor, former address Aikins Street, Winnipeg, whose case was being investigated, had left the City before legal action was taken.

(c) Re. Thonne, Physio-Therapist, Winnipeg.

Dr. Campbell informed the Committee that Thonne, Physio-Therapist, former address Main Street, Winnipeg, whose case was being investigated, had left the City before legal action was taken.

(d) Re. J. L. Davidson, Chiropractor, Winnipeg.

In reference to J. L. Davidson, Chiropractor, Somerset Bldg., Winnipeg, whose case was considered last year, the Registrar has not been able to obtain any definite evidence, consequently no action has been taken against him.

(e) Re. Thomas, Donald St., Winnipeg.

Dr. Campbell reported that Thomas, who formerly carried on at a Mayfair Street address, has a store on Donald Street, Winnipeg, where he conducts a business of selling herbs, patent medicines, etc. It is not known that he is doing any medical practice.

Re. Case of Insurance in Reference to an Automobile Accident.

Dr. ..... had attended a man at the Winnipeg General Hospital, who had received injuries in an automobile accident. This case was covered by insurance. The insurance adjuster called to see the doctor, and agreed to his fee for attendance, namely, One Hundred Dollars ($100.00). The patient employed a lawyer in the case, to whom the insurance company paid over the money in full settlement. The lawyer assured the adjuster that he would pay the doctor, the agreed fee, the hospital and the x-Ray accounts.

There is a gentleman's agreement between the Insurance Companies and the medical profession, that medical and hospital fees shall receive prior claims. The evidence, taken by the Taxing Committee in this instance, reveals that where a lawyer is handling the case, the money is paid to him on a verbal assurance, that the above mentioned accounts will receive prior consideration and on the terms agreed.

However, the lawyer called to see Dr. ....., and offered him Fifty Dollars ($50.00) in settlement. Incidentally, the lawyer's fee was One Hundred Dollars ($100.00). Dr. ..... did not comply with this settlement, on the grounds that the insurance adjuster had not considered his fee unfair or unreasonable. Dr. ..... referred this question to the College of Physicians and Surgeons of Manitoba.

Dr. Campbell reported that he had referred the question to the Taxing Committee, who had investigated the case, but had not yet had sufficient time to complete its report.

The Executive Committee would request the Registrar to suggest to the Taxing Committee that these particulars be forwarded to the Law Society.

Communication from the Manitoba Medical Association Regarding the Workmen's Compensation Board.

The following is a copy of a resolution received from Dr. Jackson, Secretary of the Manitoba Medical Association, regarding the Workmen's Compensation Board:

> "Whereas, in the regulations between the medical profession and the Workmen's Compensation Board, matters of prevention, conduct and discipline are properly the sphere of the College of Physicians and Surgeons of Manitoba, and questions regarding the scale of fees and financial returns in general are less appropriately their concern,
>
> "Therefore, be it resolved, that THE MANITOBA MEDICAL ASSOCIATION ASK THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA TO ASSUME THE FULL INITIATIVE AND RESPONSIBILITY FOR DEALING WITH QUESTIONS OF PROFESSIONAL ETHICS, and that THE MANITOBA MEDICAL ASSOCIATION CONTINUE THROUGH THEIR EXISTING REFEREE BOARD TO DEAL WITH MATTERS OF ETIQUETTE, FEE SCHEDULES AND ANY OTHER QUESTIONS which come within its particular functions and powers, and that a copy of this resolution be sent to the College of Physicians and Surgeons of Manitoba and the Workmen's Compensation Board with the request that, if approved, they take the necessary steps to complete the arrangement."

There has been no word received from the Compensation Board.

Discussion was carried on in reference to the duties this would require.

The Registrar was requested to interview Major Newcombe, Commissioner, in this connection.

Re. Dr. ....., Winnipeg, Manitoba.

The Registrar reported that Dr. ..... owes the amount of Fifty Dollars on his demand note, re. license issued December 3rd, 1917, and Twelve Dollars, Annual Fees.

Moved by Dr. McDiarmid, seconded by Dr. Rennie: "That the Registrar be instructed to write Dr. ....., advising him that he owes Sixty-Two Dollars, and that if this amount is not paid before the next meeting of the Council, his case will be presented for further necessary action." —Carried.

Re. Committee of Twelve.

Dr. Campbell reported that he had assembled a meeting of the members of the Committee of Twelve on Friday, April 26th, 1935, for organization purposes and to be prepared to combat any legislation proposed by irregular practitioners.

Dr. G. S. Fahrni was appointed Chairman, and Dr. C. W. MacCharles, Secretary.

Dr. Campbell asked that he might sit in at the meetings, as he might have information of assistance.

Dr. Campbell informed the Committee of Twelve that he thought the Council of the College of Physicians and Surgeons of Manitoba would authorize the payment of the travelling expenses of a member attending district meetings, for the purpose of soliciting the assistance of every medical practitioner in the province.

Re. Calling a Council Meeting.

Dr. Campbell stated there was not sufficient business at present to necessitate calling a meeting of the Council, and requested the advice of the Executive Committee.

The committee considered it was unnecessary to call an immediate meeting.

OBITUARY

DR. E. J. BOARDMAN

While visiting his daughter in Saskatoon, Dr. Edmond James Boardman, prominent urologist of Winnipeg, died suddenly of coronary thrombosis on May 12th. Born at Shediac, N.B., in 1878, he came to Winnipeg with his parents in 1881, was educated in the public schools and St. John's College, and graduated in medicine from Manitoba Medical College in 1907. After engaging in general practice he devoted himself from 1918 onward to urology, and in 1928 was appointed Assistant Professor of Clinical Surgery (Urology) in the Faculty of Medicine. He was Urologist at St. Boniface Hospital.

In 1928 he was elected President of the Manitoba Medical Association, and in this capacity he rendered valuable service to organized medicine. He was Chairman of the Auditorium Committee in connection with the meeting of the British Medical Association at Winnipeg in 1930, and Honorary Secretary of a joint committee of the Manitoba Medical Association and the College of Physicians and Surgeons of Manitoba to consider the matter of Public Medical Services.

Masonry attracted him strongly, and he received many honours from the Craft; the chief being his election to the office of District Deputy Grand Master.

He is survived by his widow, one son and two daughters. An able speaker, a sound clinician and a good teacher, Dr. Boardman will be greatly missed in medical circles.

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DR. FREDERICK LAURENCE SCHAFFNER

Dr. Frederick Laurence Schaffner, member of the Canadian Senate for Manitoba since 1917, died on May 22nd at his home in Winnipeg. He was born in 1855 at Williamstown, Nova Scotia, and was descended from one of the German colonists who had settled in Nova Scotia in 1750. He received his B.A. degree from Acadia College and his M.D. from Toronto University. He spent two years in post-graduate work in Chicago and New York. After practicing for a few years in the East he came to Manitoba in the early 90's and located at Boissevain where he soon acquired a successful practice and took an active part in public affairs. In 1904 he was elected member of the newly created constituency of Souris and was re-elected in 1908 and 1911. He served during the war and was Chief Sanitary Officer for Camp Hughes, with the rank of Captain. In 1917 he became D.A.Q.M.G. for Military District No. 10. He was appointed to the Senate on October 23rd, 1917. In 1926 he was the Canadian delegate to the British Empire Parliamentary Association which made a tour of Australia. He is survived by his widow. Dr. Schaffner took a keen interest in Manitoba Sanatorium at Ninette.

MEDICAL LIBRARY—*Continued*

"The Clinical Journal"—April, 1935.

"Eczema as a Clinical Entity and its Fundamental or Essential Lesions" — by H. G. Adamson, M.D., F.R.C.P., St. Bartholomew's Hospital.

"The Diagnosis and Treatment of Bronchiectasis" —by William Brockbank, M.A., M.D., M.R.C.P., Manchester.

"A Method of Dealing with the After-Coming Head in Breech Presentations" — by John William Burns, M.D., F.R.C.S. (Edin.), F.C.O.G., Liverpool.

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NEWS ITEMS

RURAL SANITATION: The following is an article written by Cecil K. Blanchard relative to the establishment of privies, which we think will be of interest to practising physicians in rural Manitoba, and possibly, more particularly of interest to the Medical Officers of Health. May we remind you that our Division of Sanitation will be glad to render any assistance they can to help you solve your sanitary problems.

Mark Time stood in front of the Mason Block, near the entrance marked "Township Hall," and looked up and down the street. Spring had come. The large maple tree in Doctor Symptom's yard was red with opening buds. Birds twittered. Mud was turning to dust at last.

As Mark noticed these signs, one by one, he became conscious of sounds not heard in Piketown for many months—the noise of carpenters. Yes, there was no mistake, the sounds were those of hammer and saw. They seemed to come from behind Hustler's Garage.

With moderate speed, becoming his age, Mark crossed the street and walked around the end of the garage. There stood Ben Hustler beside the frame of a very small building on which two local carpenters were working. Ben caught sight of the assessor and called out, "Come here, Mark, if you want to see how an outdoor toilet ought to be built."

Mark joined the three men and looked from one to another, his bushy eyebrows drawn together but with the suggestion of a smile. "Is this the start of the big building revival I've been reading about?" he asked.

"You'll have to admit this is the first new building to go up in Piketown in four years," declared Hustler after the general laughter had subsided.

"I guess you're right, Ben; guess you're right. But, say, what's your idea in building a privy out here? There's a flush toilet in the garage."

"Yes, so there is but—to tell the truth, I had three ideas in putting up this toilet. First, there's no fit place for a stranger to go when the garage is closed. So this will be a sort of public comfort station."

"That's a fact; we do need such a place in the village," Mr. Time agreed.

"Second, this will be a sample of a good, cheap, sanitary toilet," continued Ben. "Folks who need a new one can take a look at this and see the latest model."

"Not a bad idea and you're the one who would think of it—as usual."

"Third, the boys here will try out these plans and keep track of the cost and be all ready to quote a price on each of the 999 new toilets needed in this part of the county. It may start a building boom, like you said."

"I believe you're serious about this, Ben."

"Sure, I'm serious. Everything I said is so; we need a public toilet, folks need a sample of the best kind and carpenters need work. What's the matter with the ideas?"

"Why nothing s'far as I can see; they sound practical. You said something about plans. What plans?"

"The plans for a cheap, sanitary privy the Department of Health gives away. Where are those plans, Bob? Oh, here they are."

Mr. Time located his glasses after a brief search, put them on, rested his right foot on a pile of boards and looked at the plans. After a casual examination, he handed them back. "I don't understand drawings. Show me how you're going to build it."

The carpenters had finished the frame and were now sawing boards to sheath the back wall. Ben and Mark leaned over the horizontal nailing tie on one side of the building as they talked. "You see," began Hustler, "there's a pit with concrete walls about four feet deep. Wood would be cheaper but concrete will last. The pit is all under the building. The seat box sits right on the wall of the pit, with a tight joint."

"Seat box, eh. Oh, I see, the seat is not a part of the building."

"That's right. The pit, seat box and seat covers really are the toilet. The building is just a shelter put over them."

"Why do you think that is better than the old style, with the pit partly outside and covered with a hinged door?" asked Mark.

"Because it's easier to build and easier to keep tight. In the old type privy, the hinged cover on the pit is exposed to rain and sun so it usually warps and shrinks and the hinges rust off after a while. That lets flies in where the filth is stored. Here the whole thing is inside, protected from the weather."

Mark examined the construction more closely. "H'm. The building doesn't touch the seat box, so you can tip it up on edge to clean out the pit. I should think it would be easier to build. You say you got the plans from the Department of Health?"

"Yes, and besides these plans there is a lumber list and they even tell you how to cut the lumber to avoid waste."

"I suppose the board of health ought to have one or two of these sets of plans on hand," suggested Mr. Time.

"Why not send for some and be ready—?" Loud honks interrupted Ben Hustler's remarks. "Sounds like business, boys; see you after a while, Mark," and the most energetic man in town disappeared into the shadows of his public garage by way of the rear door.

COMMUNICABLE DISEASES REPORTED

Urban and Rural : April, 1935

Occurring in the Municipalities of:—

Measles: Total 517—Winnipeg 148, Unorganized 73, Cameron 43, Hamiota Village 40, Boissevain 21, Charleswood 18, Louise 16, St. Vital 12, Dauphin Town 12, Gleenwood 12, Woodworth 11, Virden 11, Arthur 10, Richot 10, Whitemouth 9, Miniota 8, Ethelbert 8, Silver Creek 5, Minnedosa 4, Thompson 4, St. James 3, Swan River Rural 3, Russell Rural 3, Bifrost 3, Dauphin Rural 2, Kildonan West 2, Roland 2, Strathcona 2, Whitewater 2, Clanwilliam 1, Edward 1, Fort Garry 1, Glenwood 1, Morton 1, Pilot Mound 1, Portage City 1, Portage Rural 1, Rockwood 1, St. Boniface 1, The Pas 1, Wawanesa 1. Late Reported, February: The Pas 2, Roland 1, Brandon 1. March: Unorganized 2, St. Boniface 2.

Mumps: Total 200—Winnipeg 192, St. Vital 3, Kildonan East 1, Kildonan West 1, Selkirk 1, St. James 1, Transcona 1.

Whooping Cough: Total 158 — Winnipeg 114, St. Vital 10, Brandon 6, St. James 6, St. Boniface 4, Whitehead 4, Fort Garry 3, Norfolk North 2, Coldwell 1, Kildonan East 1, Portage Rural 1, Unorganized 1. Late reported, March: St. Boniface 5.

Chickenpox: Total 134—Winnipeg 100, Unorganized 14, St. James 5, Lorne 5, Eriksdale 4, Virden 3, Kildonan West 1, St. Boniface 1, Fort Garry 1.

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Tuberculosis: Total 61—Winnipeg 22, Unorganized 4, Brokenhead 3, Dauphin Rural 2, Hanover 2, Kildonan East 2, Minnedosa 2, St. Boniface 2, St. James 2, St. Laurent 2, Brandon 1, Cornwallis 1, Daly 1, Dufferin 1, Edward 1, Emerson 1, Gilbert Plains Rural 1, Hillsburg 1, Lac du Bonnet 1, Lorne 1, Morton 1, Neepawa 1, Norfolk South 1, Selkirk 1, Strathcona 1, St. Andrews 1, St. Clements 1, Transcona 1.

Scarlet Fever: Total 59—Winnipeg 29, Unorganized 6, Gilbert Plains Village 2, Kildonan East 2, Portage Rural 2, Rhineland 2, Roland 2, Rosedale 2, Fort Garry 1, Louise 1, Minitonas 1, Shoal Lake Rural 1, Strathclair 1, St. Vital 1, Tache 1, Thompson 1, Transcona 1, Tuxedo 1. Late reported, March: Swan River Town 2.

Diphtheria: Total 26—Winnipeg 10, La Broquerie 2, Morris Rural 2, Ste. Anne 2, St. James 2, Edward 1, Langford 1, Neepawa 1, Rhineland 1, Unorganized 1, Whitemouth 1. Late reported: January: Rhineland 1. March: Ethelbert 1.

Erysipelas: Total 9—Winnipeg 6, Rosser 1, Hillsburg 1. Late reported: January: Coldwell 1.

Influenza: Total 5—Late reported, January: Portage City 1. February: Ethelbert 1, Portage City 1, Selkirk 1, Unorganized 1.

German Measles: Total 4—Kildonan East 1, St. James 1. Late reported, March: St. Boniface 2.

Undulent Fever: Total 4—Minnedosa 2, Minto 1. Late reported, January: Minnedosa 1.

Puerperal Fever: Total 2—Siglunes 1, Victoria 1.

Trachoma: Total 2—Landsdowne 2.

Diphtheria Carrier: Total 2—Winnipeg 2.

Cerebrospinal Meningitis: Total 1—Bifrost 1.

Typhoid Fever: Total 1—Winnipeg 1.

Venereal Diseases: Total 105—Gonorrhoea 69, Syphilis 36.

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DEATHS FROM ALL CAUSES IN MANITOBA

For the Month of March, 1935

URBAN—Cancer 38, Tuberculosis 9, Pneumonia (all forms) 4, Lethargic Encephalitis 2, Puerperal 2, Erysipelas 2, Venereal Disease 2, Diphtheria 1, Influenza 1, All others under 1 year 7, all other causes 144, Stillbirths 20. Total 232.

RURAL—Pneumonia (all forms) 29, Cancer 27, Tuberculosis 16, Measles 6, Influenza 5, Puerperal 4, Lethargic Encephalitis 1, Scarlet Fever 1, All others under 1 year 13, all other causes 175, Stillbirths 24. Total 301.

INDIANS—Tuberculosis 11, Pneumonia 7, Whooping Cough 5, Measles 3, Scarlet Fever 2, Cancer 1, all others under 1 year 2, all other causes 10, Stillbirths 3. Total 44.

Notice

Dr. W. J. Neufeld is leaving Winnipeg June 3rd for a six months' trip to Europe. Dr. Neufeld will attend the Surgical Clinic at Leipsic with Professor Payr. Dr. A. M. R. Fargey will attend to his practice at 604 William Avenue until he returns.